STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Integrity Back and Brain, LLC
Petitioner **File No. 21-1586**

v

Progressive Michigan Insurance Company
Respondent

Issued and entered
this 14th day of January 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On October 7, 2021, Integrity Back and Brain, LLC (Petitioner) filed with the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of Progressive Michigan Insurance Company (Respondent) that the cost of treatment, products, services, or accommodations that the Petitioner rendered was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Respondent issued the Petitioner a bill denial on September 17, 2021. The Petitioner seeks reimbursement in the full amount it billed for the dates of service at issue.

The Department accepted the request for an appeal on October 13, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on October 13, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Department issued a notice of extension to both parties on December 1, 2021.

II. FACTUAL BACKGROUND

This appeal concerns the appropriate reimbursement amount for home health aide services rendered on July 3 and 4, 2021 under Healthcare Common Procedural Coding System (HCPCS) Level II code S9122, which is described as a home health aide or certified nursing assistant providing care in the home, per hour.

With its appeal request, the Petitioner submitted documentation that included an *Explanation of Review* letter issued by the Respondent, a referral from a physician ordering 24 hour, 7 days a week home nursing care, a copy of *Medicare Publication of Home Health Prospective Payment System*, and its reason for appeal.

In its appeal request, the Petitioner stated:

> We are asking [the Department] to compel [the Respondent] to properly apply the law and Medicare Fee Schedule when computing the proper payment amount for the services we have provided. If [the Department] does not or can compel the [Respondent] we will be forced to take legal action. It is clear in the law and confirmed [through the Department's] bulletins and, Q and A's that the new law does not impose on us any extra requirements that network participation in Medicare would otherwise require. This means requirements such as accreditation, application of [local coverage determinations], [patient-driven groupings model], need for a [national provider identifier] or any other similar requirements are not required or applicable to our situation. In addition to this the new law clearly states when there is a posted Medicare rate for a valid HCPCS code that the provider is [entitled] up to 200% of the posted Medicare rate.

It its *Explanation of Review,* the Respondent indicated that the Petitioner's reimbursement amount is based on the applicable percentage of the Provider's Charge Description Master (CDM). The Respondent did not submit a reply to the Department regarding this appeal.

On October 13, 2021, the Department requested the Petitioner submit is 2019 CDM. See MCL 500.3157(7). The Petitioner submitted its CDM to the Department on October 14, 2021.

III. ANALYSIS

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding cost.

For dates of service after July 1, 2021, MCL 500.3157 governs the appropriate cost of treatment and training. Under that section, a provider may charge a reasonable amount, which must not exceed the amount the provider customarily charges for like treatment or training in cases that do not involve insurance. Further, a provider is not eligible for payment or reimbursement for more than specified amounts. For treatment or training that has an amount payable to the person under Medicare, the specified amount is based on the amount payable to the person under Medicare. If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under MCL 500.3157(2) through (6), the provider is not eligible for payment or reimbursement of more than a specified percentage of the provider's charge description master in effect on January 1, 2019 or, if the provider did not have a charge description master on that date, an applicable percentage of the average amount the provider charged for the treatment on January 1, 2019. Reimbursement amounts under MCL 500.3157(2), (3), (5), or (6) may not exceed the average amount charged by the provider for the treatment or training on January 1, 2019. See MCL 500.3157(8); MAC R 500.203.

Based on its review, the Department determined that HCPCS code Level II S9122 does not have an amount payable under Medicare. Accordingly, to calculate the appropriate reimbursement amount the Department relied on the Petitioner's submitted CDM as of January 1, 2019 for HCPC Level II code S9122. Pursuant to MCL 500.3157(7), the amount payable to the Petitioner for the procedure code at issue is $[redacted] per hour for the July 3, 2021 date of service (non-holiday) and $[redacted] per hour for the July 4, 2021 date of service (holiday). The Respondent issued the Petitioner reimbursement in the amount of $[redacted] per hour for all dates of service at issue. Accordingly, the Department concludes that the Petitioner is due additional reimbursement for the dates of service at issue.

IV. ORDER

The Director reverses the Respondent's determination dated September 17, 2021 that the cost of the treatment rendered on July 3 and 4, 2021 was inappropriate under Chapter 31 of the Code MCL 500.3101 to MCL 500.3179.

The Petitioner is entitled to reimbursement in the amount payable under MCL 500.3157 for the treatment on the dates of service discussed herein, and to interest on any overdue payments as set forth in Section 3142 of the Code, MCL 500.3142. R 500.65(6). The Respondent shall, within 21 days of this order, submit proof that it has complied with this order.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial

review should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford